Working from inside out: Prescribing management in Primary Care Groups

Prescribing in NHS general practice P has traditionally been viewed as an individual act perform individual practitioners for their individual patients. Family doctors were free to judge the quality and appropriateness of their own prescribing Few attempts were made to facilitate the comparison of prescribing behaviour between peers. Policy designed to improve prescribing quality was primarily aimed at improving the information and training received by individual doctors.

In April 1991. budgets for practice pharmaceutical expenditure were introduced as part of the fundholding and indicative prescribing schemes. They were designed to give all practices a financial allocation for drugs, which indicated the amount that they should spend on pharmaceutical products during a particular financial year. The initiatives differed in that the GP fundholding scheme contained budget elements for services other than prescribing and, initially, embodied much stronger incentives to control costs than the indicative prescribing scheme. Evidence about their relative effects suggests that the fundholding scheme led to one-off savings in prescribing expenditure, which usually occurred during a practice's first year in the scheme. Non-fundholding practices, on the other hand, tended to overspend the allocations that they were set.

During the mid-1990s, many new initiatives were introduced in an attempt to further improve prescribing in NHS general practice. Prescribing Analysis and CosT (PACT) data became available electronically. The PRODIGY system was developed and evaluated. Greater incentives were offered to nonfundholding practices. Nurse prescribing schemes were piloted in a small number of practices. Pharmacists began to work with some doctors to help them manage their prescribing quality and costs.

Prescribing in the new NHS

New NHS white paper published in December 1997 introduced Primary Care Groups (PCGs) throughout England (and equivalent organisations in Scotland and Wales) each of which would be allocated a unified budget for the purchase of hospital, pharmaceutical and other services. PCGs are expected to contain expenditure on all services by local practices within their allocated sums. As part of these arrangements, PCGs were instructed to set each local practice a budget for drugs, as had occurred under the fundholding scheme.

To help improve standards in the NHS. the introduction of PCGs was accompanied by a range of other initiatives. A series of National Service Frameworks has been initiated in order to set standards in major disease areas. All health authorities have been instructed to produce local Health Improvement Plans. The Commission for Health

Improvement was established to monitor standards in primary and secondary care. The National Institute for Clinical Excellence has been established, to vet the effectiveness and cost-effectiveness of new and existing health technologies. including pharmaceuticals. Underpinning all of these measures is an increased emphasis on setting and monitoring quality standards within the NHS. In consequence, PCGs were not only instructed to stay within their unified budgets but with meeting national and local standards set by outside agencies.

The individual and the group

PCGs are based upon the idea that general practitioners would work together in order to improve local primary care services. The new policy is designed to reject the competitive, market-based approach favoured by the previous government and to achieve beneficial change through co-operative working. Although a good idea in theory. general practitioners have had little experience of working together outside their own partnerships or out-of-hours co-operatives. Therefore. PCGs were introduced with little evidence of what factors do and do not make successful group working in NHS general practice.

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In principle, one of the main limitations of the co-operative approach suggested for PCGs is that some participating individuals may have to make personal sacrifices for the good of the group. For example, practitioners on a PCG board may have to agree with a means of setting drug budgets that limits the funds received by their own practices. Although a fair allocation process could ensure that such decisions were made equitably, affected individuals may find it difficult to subsume their personal interests to those of the group. Consequently, friction may be caused. as cash-limited. unified budgets cannot be managed without some local sacrifices being made.

Insiders and outsiders

The need for local co-operation could encourage some practitioners to engage with their governing PCGs and leave others on the outside. Individuals who decide to work with or for their local PCGs may do so for both positive and negative reasons. Some may seek the power that involvement offers. Others may wish to protect their personal and practice interests. On the other hand. some practitioners may refuse to work with their local groups, as they disagree with their policies or approach. Others may be excluded because they lack the time or ability that involvement requires. Given these factors. PCGs may find themselves working with a local community of 'insiders' and 'outsiders' who may wish to be either involved or uninvolved in activities that they undertake. Although the existence of insiders may allow PCGs to make local health care decisions, the non-involvement of outsiders may affect the success of the initiatives that they

introduce. For example, a PCG may not require the support of all local practitioners to set practice prescribing budgets. However, their co-operation may be required if the allocated sums are not to be exceeded. In consequence, PCGs may need the co-operation of both insiders and outsiders if their policies are to be a success.

Opportunities and strategies

The degree to which PCG boards secure the outcomes expected of them will depend upon their local circumstances and the effectiveness of the strategies that they adopt. Evidence from the fundholding scheme suggests that practices (and consequently PCGs) are more able to control their drug costs if significant savings can be generated through increased generic prescribing. With high levels of generic substitution already achieved in many areas and recent increases in non-proprietary prices, the ability of some PCGs to control local prescribing expenditure through this means may be severely limited. In consequence. some practices may have to consider the rationing of pharmaceutical products in order to gain the level of fiscal control required by their PCGs - a situation likely to be unacceptable to many.

Unless new opportunities for creating savings are continually created by the loss of patent protection for major, blockbuster products, PCGs may struggle to control their local pharmaceutical costs. In response, many may introduce a range of strategies designed to limit the growth in their drug expenditures. For example. some may employ their own prescribing advisers. Local formularies may be developed. Incentives may be used to encourage financial management. Pharmacists may be employed to work in some practices. Certain drugs may be recommended for prescribing solely in secondary care. Newsletters and local guidelines may be produced. Most importantly local practitioners may share PACT data on a named basis. which would allow the direct comparison of costs and prescribing behaviour between individuals.

Although PCGs have a range of medicines management strategies at their disposal. few have yet proven their effectiveness in the longer-term. For example, the sharing of PACT data may fail to control local prescribing costs, if this alerts some practitioners to the inadequacy of the budgets that they have been set. The introduction of such strategies may also be affected by the extra investment that their implementation requires. For instance, new resources may be required to measure local prescribing performance, to employ practice pharmacists, or to produce PCG newsletters and guidelines. In consequence. PCG prescribing strategies may only be effective if they have the opportunities, resources and practitioner support necessary for success.

Implications for practitioners and patients

From a practitioner viewpoint, the introduction of PCGs has the potential to reduce their clinical freedom and financial autonomy. Some practitioners may attempt to protect their personal interests by becoming PCG insiders. Others may lose under the new

system, as they either disagree with local PCG policies or lack the time or ability necessary to represent themselves directly. Whether or not a particular PCG achieves its planned objectives may depend upon the sacrifices that its insiders are willing to make and the proportion of local practitioners that engage in the implementation process

The effects of the PCG system on individual patients may depend upon the influence of their personal practitioners and the degree to which they are willing to subsume their interests for the od of the local population as a whole. In other words. a form of otierism' may arise in which patients of doctors working the or for their local PCG may gain at the expense of those hose practitioners are on the outside. In response, some patients may find it necessary to form into groups with other patients in order to represent their joint interests to their local CG boards. Indeed. co-operation amongst practitioners may lead to co-operation amongst patients, if they perceive their needs are not being met.

Implications for the pharmaceutical industry

Although the introduction of unified budgets suggests that greater control will be exerted over pharmaceutical expenditure in primary care, in the longer-term NHS spending on drugs is likely to continue to rise. Indeed, pharmaceutical innovation, an ageing population and increasing patient expectations may force the Government to allow greater and greater public expenditure on drugs. Therefore, the issue of concern to pharmaceutical companies should not be whether fewer drugs will be prescribed in new NHS but whether they will win or lose following the changes.

One way in which pharmaceutical companies may understand the influences on prescribing behaviour in the new NHS is to view individual practitioners as either inside or outside of their PCGs. Using this model, marketing and sales campaigns may be designed to take account of the differences between 'insiders' and 'outsiders' in NHS primary care. Individuals in the former group could be targeted in terms of their ability the degree to which they are willing to subsume their interests for the od of the local population as a whole. In other words. a form of o-tierism' may arise in which patients of doctors working th or for their local PCG may gain at the expense of those hose practitioners are on the outside. In response, some atients may find it necessary to form into groups with other atients in order to represent their joint interests to their local CG boards. Indeed. co-operation amongst practitioners may ead to co-operation amongst patients, if they perceive their needs are not being met. Implications for the pharmaceutical industry Although the introduction of unified budgets suggests that greater control will be exerted over pharmaceutical expenditure in primary care, in the longer-term NHS spending on drugs is likely to continue to rise. Indeed, pharmaceutical innovation, an ageing population and increasing patient expectations may force the Government to allow greater and greater public expenditure on drugs. Therefore, the issue of concern to pharmaceutical companies should not be whether fewer drugs will

be prescribed in new NHS but whether they will win or lose following the changes. to set local priorities and to recommend strategies for changing the prescribing behaviour of their peers. Those in the latter could be approached as individuals either willing to work outside local priorities or unable to engage in the PCG decision-making process. Through such an approach, individual companies could influence whether it is their products or those of their competitors that are prescribed in the new NHS.

An uncertain future?

PCGs are currently a good idea that has yet to prove itself in practice. Although much effort has been expended in establishing the groups, it is not yet clear whether all practitioners will accept the personal sacrifices that PCG involvement may demand. An increasing number of practitioners may decide to position themselves outside of the PCG decision-making and implementation process, if such sacrifices become unacceptable. If a significant number of doctors decide to occupy such a position, in the longer-term the government's new health policy experiment may do little to control the quality and costs of prescribing in NHS general practice.

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